Central West **LHIN**
RLISS du Centre-Ouest

Better Care through Healthy Change

2012-2013 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Central West LHIN Annual Report
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Message from the Board Chair and CEO

On behalf of the Central West LHIN, we are pleased to share the 2012/2013 Annual Report. This report outlines the progress made by the Central West LHIN for the fiscal year April 1, 2012 – March 31, 2013.

It was a busy and successful year which included the development of our third Integrated Health Services Plan (IHSP 3). This plan outlines the actions we will take over the next three years to ensure the right services are available in the right place at the right time, tailored to meet local needs. An extensive community consultation process was undertaken to develop the plan which is built around four strategic directions. They are:

- Improve access to care
- Streamline transitions and navigation of the system
- Drive quality and value
- Build on the momentum

Many of the projects that we undertook in 2012 helped us improve access to services for residents in the Central West LHIN. In the fall, we allocated $5.5 million towards community-based programs to improve access to services for seniors and other residents with home care and mental health and addictions needs.

The Behavioural Supports Ontario (BSO) project was fully implemented at the beginning of 2013. Success stories from long-term care facilities across the LHIN confirmed that the addition of 26 new specialized roles was a sound investment.

We were also fortunate to be one of the LHINs chosen to implement Health Links. Health Links is a great example of integration because it brings together family doctors, specialists, the Central West Community Care Access Centre (CCAC), hospitals and community providers in a voluntary way to develop coordinated care plans to support seniors and patients living with complex conditions. We are currently working to develop five Health Links in the Central West LHIN.

Technology moved us ahead in 2012/2013 with a large percentage of our primary care providers and specialists moving to an Electronic Medical Record (EMR) system. For many family physicians and specialists, the EMR streamlines their processes and creates a much more efficient system of managing information.

In addition, we were one of three LHINs chosen by the Ministry to pilot the Telehomecare project. This is another great example of using technology to improve patient self-management, reduce emergency department visits and decrease hospital readmissions.

Last fiscal year we saw three satellites of Community Health Centres move forward. Bramalea Community Health Centre opened the Four Corners Health Centre in Malton, while in north Etobicoke, the Jamestown and Kipling-Dixon satellites of the Rexdale Community Health Centre received capital funding to complete renovations to their buildings.

We did a lot of community engagement as well. In addition to sessions for developing the IHSP 3, we also organized events with women and children's groups to gather feedback on local health care services. At the end of 2012, we partnered with several of our Health Service Providers in a Telephone Town Hall. This provided a forum in which community members could ask questions about local health care services and receive a live answer from a senior representative of each organization.

The results of these engagements will help us understand the community's views on current services in the health care system. Feedback will be used to make improvements and continue to build on the momentum of past progress.

2012 also saw the appointment of a new CEO. New leadership encourages more opportunities and a fresh perspective that has helped the LHIN move forward into a new year.

Indeed, the past year has been eventful with much progress to note. We look forward to continuing to listen so we can improve, build and streamline local health care services for residents in the Central West LHIN.

Sincerely,

Maria Britto
Board Chair of the Central West LHIN

Scott McLeod
CEO of the Central West LHIN

Population Demographics

The Central West LHIN serves the communities of Brampton, Caledon, Dufferin County, Malton, Rexdale and Woodbridge. The community represents 6.5% of Ontario's population, serving a diverse and growing population of approximately 850,000 people. The LHIN has experienced unprecedented growth as the population grew by 14% from 2006 to 2011, which was one of the highest amongst all LHINs and higher than the Ontario growth rate of 5.7%. The population of the Central West LHIN is expected to grow by 26% between 2006 and 2016.

Map of the Central West LHIN

The Central West LHIN has a highly ethno-culturally diverse population, with 46% identified as newcomers and over 50% as visible minorities. This rich diversity requires that health services be sensitive with respect to language barriers and cultural beliefs, and focus on preventing and treating diseases that are frequently seen in these populations.

Community	Population	% of the Populations
Brampton	523,911	62.3%
Caledon	59,460	7.0%
Dufferin	56,881	6.8%
Malton	40,304	4.8%
Rexdale	130,193	15.5%
Woodbridge	30,476	3.6%
Central West LHIN	**841, 225**	**100%**

Health Population Profile

The populations of the Central West LHIN is younger compared to the province's total population and the lowest among the 14 LHINs. The average age of the Central West population in 2006 was 34.9 years, and for Ontario it was 40.4 years.

Programs Funded

The Central West LHIN funds 53 health service programs worth $831 million. Programs include:

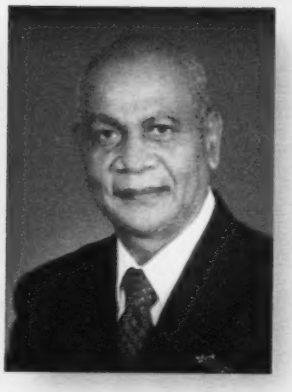
- Two Community Health Centres with three satellite locations
- One Community Care Access Centre
- Two hospital corporations
- Nine mental health and addictions services
- Twenty-four Long-Term Care facilities
- Fifteen Community Support Services
- Five Health Links

Board Members

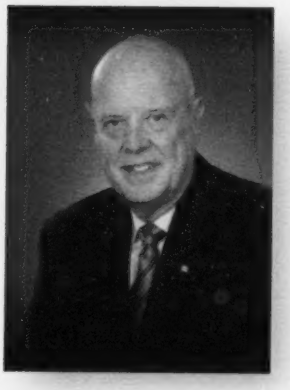
Maria Britto
Chair
June 9, 2011 –
June 8, 2014

Lorraine Gandolfo
Member
Oct. 27, 2010 –
Oct. 26, 2013

Suzan Hall
Member
May 17, 2011 –
May 16, 2014

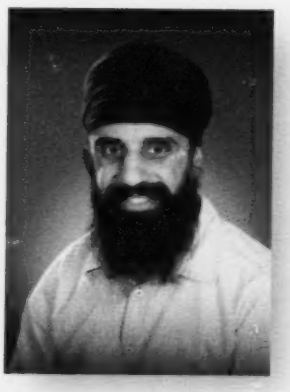


Winston Isaac
Member, reappointed
Jan. 13, 2012 –
Jan. 12. 2015

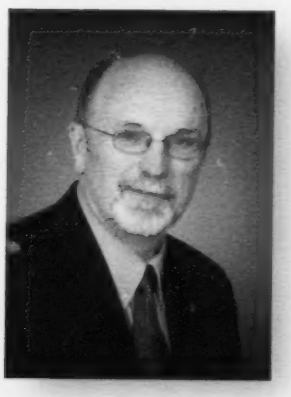


Hon. John McDermid
Member
June 9, 2011 –
June 8, 2014

Gerry Merkley
Member
June 17, 2010 –
June 16, 2013



Pardeep Singh Nagra
Member
June 9, 2011 –
June 8, 2014



Ken Topping
Member
Oct. 6, 2010 –
Oct. 5, 2013

Programs and Initiatives in the Central West LHIN

Behavioural Supports Ontario (BSO)

The BSO project started in early 2012 and was fully implemented throughout the Central West LHIN by the beginning of 2013. BSO was created to enhance services for seniors with complex behaviours due to dementia, mental health and addictions or other neurological conditions.

To ensure seniors received the right kind of treatment in the right place, the Central West LHIN created a network of care by funding 26 new specialized BSO staff who work in long-term care facilities. This staff works closely with health care workers in long-term care facilities to identify triggers of responsive behaviours and develop strategies for modifying these behaviours with much success. As a result, seniors are getting better care because they are understood better.

"I'm glad to finally see the health care industry is paying attention to the elderly, especially people with dementia," says Steven Petgrave, son of a BSO patient. "My father has always been an independent person and this is very confusing for him."

By the time the project was fully implemented throughout long-term care facilities in the Central West LHIN, more seniors and their caregivers were being supported by BSO staff.

Community Support Services Funding

The Central West LHIN received $5.5 million from the Ministry of Health and Long-Term Care to better support residents through enhanced community support services.

Expansion of services includes helping seniors and residents stay independent in their home by providing increased levels of nursing and homemaking services. In addition, seniors will have access to health services and therapies that can be performed right in their home such as infusion therapy, negative pressure wound therapy for eligible clients, and rehabilitation services for seniors who have had hip and/or knee replacements.

Funding was also allocated to expand access to addiction treatment to provide programs and support for pregnant and parenting women with opiate addictions and youths with addictions issues. Six Health Service Providers came together to develop a case to expand access to mental health and addictions services in communities across the Central West LHIN.

This funding will also increase hours for PSWs (Personal Support Workers) in the next three years. Not only will this benefit seniors and residents who need this care, but increase employment opportunities for these important health care workers.

This investment will also help free up hospital and long-term care beds, shorten emergency room wait times and reduce the number of readmitted patients.

Community Health Centre Satellites

Four Corners Health Centre

The Four Corners Health Care Centre, a satellite of the Bramalea Community Health Centre opened in the fall of 2012 and will provide health care services to the residents of Malton. The Services at the Centre include primary care services delivered by a growing team of doctors, nurse practitioners, nurses and diabetes educators as well as a physiotherapist, a chiropodist and a social worker.

Jamestown and Kipling-Dixon Satellites

In the past year, the Central West LHIN continued to provide funding for health care services at the Jamestown and the Kipling-Dixon satellites of Rexdale Community Health Centre. In early spring 2013, the Ministry of Health and Long-Term Care provided capital funding to support the Jamestown Satellite's move into the newly renovated building, and for improvements to the Kipling-Dixon Satellite that will expand the space available for delivering high quality health care services.

Diversity and Health Equity

The Central West LHIN continues to work with Health Service Providers to develop strategies to remove barriers to health care services for marginalized communities in the Central West LHIN.

The Health Equity Impact Assessment Tool (HEIA) was implemented in the Central West LHIN in partnership with the Ministry of Health and Long-Term Care. This flexible and practical assessment tool is being used by both William Osler Health System and Headwaters Health Care Centre to identify potential health impacts (positive or negative) of a plan, policy or program on vulnerable or disadvantaged groups within the general population.

e-Health Initiatives

Integrated Assessment Record

In fall 2012, all Central West LHIN providers in the community services sector and many mental Health Service Providers adopted the Integrated Assessment Record (IAR) tool. The IAR allows client assessments to move with the client from one Health Service Provider to another. It allows participating Health Service Providers to upload and view the information from consenting clients. This enables Health Service Providers to collaborate in order to effectively plan and deliver care. The tool also streamlines patient information so there is less duplication and faster access to services.

EMR Adoption

By the end of 2012 over 76% of family physicians and 49% of specialists in the Central West LHIN moved to an Electronic Medical Record (EMR) system to better manage patient information. This is the highest rate of adoption among family practitioners and specialists in the province.

By adopting an EMR system, physicians can share lab tests and specialist results electronically within days, which enables patients to receive information faster. Patients can even allow their pharmacists to view the information electronically which allows for renewals of prescriptions.

This reduces errors because now, reading the physician's handwriting becomes a non-issue. In addition, the EMR system has added efficiency for physicians that allows them to manage diabetic patients better, ensures more effective

> ***"The EMR has added efficiency that allows me to manage my diabetic patients better, ensures more effective cancer screening and disease prevention. It also really improves the patient's journey by linking Health Service Providers to share information."***
>
> - **Dr. Frank Martino, Primary Care Lead for the Central West LHIN**

cancer screening and disease prevention.

In order to further support the adoption of EMR, the Central West LHIN facilitated sessions with physicians to provide information about the benefits of moving to a paperless environment.

Emergency Department (ED) Length of Stay and Alternative Level of Care (ALC)

The Central West LHIN works closely with hospitals to develop processes to lower the length of time that patients spend in the emergency department.

In 2012/13, there were 277, 975 emergency department (ED) visits to hospitals in the Central West LHIN. 119,366 of those visits were made at the Brampton Civic Site of the William Osler Health System, which saw more ED patients than any other hospital in the province.

93% of patients treated and discharged home from the ED are completing their stay well below the target times of 8 hours for complex patients and 4 hours for less complex patients. Central West LHIN hospitals were able to improve over their already good performance for these patients, achieving a 37-minute reduction in length of stay from last fiscal year for seriously ill patients, and an 8-minute reduction for less seriously ill patients.

For patients that required admission to an inpatient bed, hospitals in the Central West LHIN achieved a 3.2 hour reduction in length of stay in 2012/13.

In order to reduce length of stay in the emergency department, the Central West LHIN works closely with Health Service Providers to ensure that there are health care services available in the community so patients do not have to stay in the hospital for care. This helps to free up beds for patients who are more seriously ill.

Patients who no longer require the intensity of services provided in the hospital are designated Alternative Level of Care (ALC). The overwhelming majority of Central West LHIN hospital patients (96%) complete their course of treatment and are discharged home without experiencing any barriers to their health system journey.

Health Links

The Central West LHIN has been approved by the Ministry of Health and Long-Term care to develop Health Links to better coordinate health care services for seniors and patients with complex disorders.

Health Links are based on a partnership of health care providers that brings together family doctors, specialists, the CCAC, hospitals and community providers to develop a coordinated

care plan for patients. Through Health Links, providers will work together to share information, develop the same understanding of the patient's condition and needs, and establish goals for the patient.

The early focus of Health Links will be on patients with complex medical needs. The intention is to improve the transitions between health care providers so patients are not dropped or lost between providers, and that providers in the circle of care know what else is going on in the patient's treatment.

Health Links will help close the gaps that often occur during the hand-off of a patient from one provider to another. Coordinating care is an important step in improving the services available to patients with complex needs. Typically, these patients have multiple chronic diseases. Many are seniors. These patients often end up in the emergency department for care and often are readmitted into hospital when they could be receiving care in the community.

So far four Health Links in the Central West LHIN have received Ministry approval of their Business Cases. These include:

- Bramalea and Area Health Link
- Brampton and Area Health Link
- Dufferin Area Health Link led by Headwaters Health Care Centre.
- North Etobicoke-Malton-West Woodbridge Health Link.

Additionally a Readiness Assessment has been prepared by the LHIN and submitted to the Ministry of Health and Long-Term Care for a fifth Health Link in Bolton-Caledon.

Integrated Health Services Plan 3

The Central West LHIN launched the third Integrated Health Services Plan (IHSP 3) in February 2013. This strategic plan is a roadmap that outlines the directions that will improve the quality of, and access to local health care services for residents in Brampton, Caledon, Dufferin County, Malton, Rexdale and Woodbridge.

In order to develop the plan, the Central West LHIN engaged in extensive community consultation with local residents and Health Service Providers, to gain feedback on local health care services. This information was used to develop four strategic directions to improve the efficiency of the health care system.

These directions outline how the Central West LHIN will focus its efforts to ensure that the right services are available at the right place and at the right time, tailored to meet local needs. They are:

- Improve Access to care
- Streamline Transitions and Navigation of the System
- Drive Quality and Value
- Build on the Momentum

The IHSP 3 aligns with Ontario's Action Plan for Health Care, in which the province set actions to build a health system that is more responsive to residents requiring health care services, and delivers improved quality of care and value for money.

Mental Health and Addictions Systems Integration Project

In 2011/2012, the Central West LHIN developed the Systems Integration Project in partnership with several Health Service Providers, the Ministry of Children and Youth Services and their agencies. The aim of this project was to guide smooth transitions for youths and young adults with mental health and addictions illnesses.

In 2012, a Systems Transition Coordinator was funded to help manage transitions between youth services and adult services, and resolve access issues for people with complex situations. This role will help sector leaders identify and resolve system-level issues based on accumulative experiences of clients. This role will also help determine the best resolutions for children with mental health and adults with dual diagnosis.

Telehomecare

The Central West LHIN recently invested $1.2 million in the Telehomecare Pilot Project.

Through Telehomecare, patients with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) will be able to manage care from the comfort of home through wireless technology. Patients will be connected to nurses who will provide remote monitoring and regular health coaching sessions to help these individuals better manage their conditions.

William Osler Health System (Osler) is the host for Telehomecare in the Central West LHIN, while the Central West Community Care Access Centre, Headwaters Health Care Centre, family health teams, primary care providers and other health service providers are playing an essential

role in referring patients to the program.

Patients will continue to have appointments with their existing health care providers as needed, and will work with dedicated nurses to set goals and learn how to manage their health through easy-to-use home monitoring equipment. The Telehomecare nurses provide regular updates to each patient's primary care provider to help form care plans and address urgent issues.

Telehomecare will improve patient self-management, reduce emergency department visits and decrease hospital admissions. Interpretive support is available upon request to patients who do not speak English or French.

Telemedicine Nurses

More residents living in the Central West LHIN will benefit from specialist care closer to home as nine new telemedicine nurses were hired at William Osler Health System, Headwaters Health Care Centre and the Canadian Mental Health Association Peel Branch. Telemedicine nurses facilitate sessions for patients who have appointments with specialists through a Telemedicine monitor. Through Telemedicine, patients can access specialists who are located anywhere in the country. This enables patients to get appointments more quickly which also eliminates the need to travel to another city to see a specialist in person.

Wait times

The Central West LHIN works closely with hospitals and Health Service Providers to develop better processes to lower wait times for surgery, MRI and CT scans. Wait times in these areas were lowered from 2011/2012 to 2012/2013 by the following:

Shorter wait time for MRI scans

The wait time for diagnostic MRI scans was reduced by 2 days.

Shorter wait time for cataract surgery

Wait times for cataract surgery were reduced by 4 days.

Shorter wait time for CT scans

Wait times for Diagnostic CT scans were reduced by 6 days.

CENTRAL WEST LHIN PERFORMANCE INDICATORS

2012/13 ANNUAL REPORT

PI No.	Performance Indicator	LHIN 2012/13 Starting Point	LHIN 2012/13 Performance Target	Most Recent Quarter 2012/13 LHIN Performance	FY 2012/13 LHIN Annual Result
Emergency Room/Alternate Level of Care					
1	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	9.69%	10.00%	11.51%	10.80%
2	90th Percentile ER Length of Stay for Admitted Patients	37.20	30.60	35.58	33.98
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7.85	7.00	7.33	7.23
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	3.78	4.00	3.65	3.65
Surgical Wait Times					
5	90th Percentile Wait Times for Cancer Surgery	54	57	52	55
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	NA	NA	NA	NA
7	90th Percentile Wait Times for Cataract Surgery	164	180	154	161
8	90th Percentile Wait Times for Hip Replacement	189	190	278	249
9	90th Percentile Wait Times for Knee Replacement	208	210	287	251
Diagnostic Wait Times					
10	90th Percentile Wait Times for Diagnostic MRI Scan	80	80	34	78
11	90th Percentile Wait Times for Diagnostic CT Scan	25	25	15	19
Excellent Care for All/Quality					
12	Readmission within 30 Days for Selected CMGs**	15.33%	14.70%	17.00%	14.88%
Mental Health and Substance Abuse					
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	14.84%	14.10%	16.44%	15.65%
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	20.10%	18.50%	26.80%	24.73%
Access to Community Care					
15	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	20	19	31	30

*FY 2012/13 is based on most recent four quarters of data (Q4 2011/12 - Q3 2012/13) due to availability

**FY 2012/13 is based on most recent four quarters of data (Q3 2011/12 - Q2 2012/13) due to availability

Performance Indicator Notes

1. Percentage Alternative Level of Care (ALC) Days – When patients are discharged from hospital beds, this indicator measures how much of their time in hospital was spent waiting for their next appropriate level of care. From January-December 2012, patients in the Central West LHIN waited the third shortest time to be discharged to their destination, more than three percentage points better than the province overall. The Central West LHIN continues to work with Health Services Providers to decrease avoidable admissions and begin the patient discharge planning process early, with the intention of decreasing the number of days patients spent waiting for an alternative level of care while occupying an acute bed.

2. 90th percentile ER length of stay for admitted patients – This indicator measures the longest time that 9 out of 10 patients who are admitted to hospital inpatient beds spend in the emergency department (ED). It includes evaluation, treatment, communication with medical professionals, and wait time for transfer to an inpatient unit. Although the length of stay for 2012/13 was 28 minutes longer than the target range, there was improvement from 2011/12 by more than three hours. This improvement is particularly impressive considering the tremendous increases in the number of emergency department (ED) visits. The Central West LHIN has the third lowest proportion of visits by population, but the Brampton Civic hospital site consistently experiences the highest volume of any emergency department in the province. The Central West LHIN also has the highest proportion of high acuity visits in the province, meaning that more of them will require admission to an inpatient bed. Initiatives in 2013/14 are specifically targeted at further improving patient flow from the ED to inpatient beds.

3. 90th percentile ER length of stay for non-admitted (CTAS I-III) patients – The clinical best practice (and provincial target) for total time spent in the ER for high acuity patients who are then discharged home is 8 hours. 9 out of 10 patients in the Central West LHIN spent at most 7.23 hours in the ED, which is within both the LHIN's target range and best practice.

4. 90th percentile ER length of stay for non-admitted (CTAS IV-V) patients – Low acuity patients require less time in the ED than high acuity patients. The best practice, provincial target, and Central West LHIN target for this measure are all the same: 4 hours. In 2012/13, patients in the Central West LHIN had the 3rd shortest length of stay of all LHIN's, spending 30 minutes less time in the ED than patients throughout the province, and 21 minutes less than the target. This success is attributed to the momentum gained by Pay-for-Results and other initiatives that have been implemented over the last several years in the ED to improve efficiency. The Central West LHIN has the lowest proportion of low acuity visits in

the province, suggesting that there has been success in providing care in a more appropriate setting for these patients, such as primary care and walk-in clinics.

5. 90th percentile wait times for cancer surgery – In 2012/13, patients waited 55 days less for cancer surgery in the Central West LHIN, meeting the LHIN target for the year, despite there being more patients to treat. This improvement is attributed to changes in data reporting for specific oncological procedures, hospital surgeons creating capacity in their elective lists, the increased utilization of Operating Room (OR) blocks, priority accorded for cancer surgeries and effective wait list management.

6. 90th percentile wait times for cardiac by-pass procedures – No hospital within the Central West LHIN provides cardiac by-pass procedures.

7. 90th Percentile wait times for cataract surgery – 9 out of 10 patients receiving cataract surgery in the Central West LHIN waited no more than 160 days for it, well below the LHIN target of 180 days and the provincial target of 182 days. This is attributed to improvement in data quality and reporting methodology, integration of the electronic booking system in the surgeons' offices, and wait list management.

8. 90th percentile wait times for hip replacement surgery – The LHIN target for wait time for hip replacement surgery was 190 days for 2012/13. 9 out of 10 patients waited at most 249 days for this surgery—this wait time is attributed to patient preference for specific surgeons, which contributes additional time for patients who choose to wait longer for a specific surgeon. The typical experience of patients in the Central LHIN is much shorter—median wait time for 2012/13 was 105 days. The Chief of Surgery is continuing to review long wait times with the surgeons. New processes are being developed to reduce and improve overall wait time.

9. 90th percentile wait times for knee replacement surgery – The experience of patients waiting for knee replacement surgery in the Central West LHIN is similar to that of patients waiting for hip replacement surgery. The LHIN target was 210 days, and 9 out of 10 patients waited at most 251 days. Median wait time (5 out of 10 patients) was much shorter, at 94 days. Patient preference for specific surgeons is again a primary contributor to long waits. The Chief of Surgery is continuing to review long wait times with the surgeons and new processes are being explored.

10. 90th percentile wait times for diagnostic MRI scan – 9 out of 10 patients in the Central West LHIN waited at most 78 days to receive their MRI scan, below the LHIN target of 80 days. An

improvement in wait time was seen despite a 24% increase in volumes. The improvement is attributed to low referral rates, more streamlined booking processes, and improvements due to technological upgrades. Ongoing monitoring through the MRI Process Improvement (PIP) will ensure sustainability and improvements in overall wait time performance.

11. 90th percentile wait times for diagnostic CT scan – 9 out of 10 patients in the Central West LHIN waited at most 19 days for a diagnostic CT scan, below the LHIN target of 25 days. A reduction in wait time was seen despite a 20% increase in volumes. The improvement is attributed to continued efforts to manage wait lists based on demand and varying levels of priority.

12. Readmission within 30 days for selected CMGs – People with certain chronic diseases tend to have hospital stays more often as these diseases progress. This measure looks at how soon after being discharged from the hospital these patients require another hospital stay. Readmission has increased steadily, and was above the LHIN target of 14.7% from October 2011-September 2012. One of the key initiatives the Central West LHIN is working on is to increase the support and self-management of chronic diseases among our population through the regional Telehomecare program. This program is intended to decrease readmission to our hospitals.

13. Repeat unscheduled emergency visits (ER) within 30 days for mental health conditions – A goal of the health care system is to better meet the needs of patients coming to the ED for mental health and substance abuse conditions, such that they are less likely to experience subsequent emergency events, and when these events cannot be avoided, the patients have access to more appropriate resources to deal with them. This measure looks at how many patients return to the ED after an initial visit for these conditions. From October 2011-September 2012, repeat ER visits were above the LHIN target of 14.1%. For mental health conditions, stress-related and neurotic disorders result in the most repeat visits. The Central West LHIN is continuing to work with Health Services Providers to learn about patient experience to improve access and use of community and crisis services, to decrease re-visit rates to the emergency departments.

14. Repeat unscheduled emergency visits within 30 days for substance abuse conditions – This measure is similar to the repeat ER visits for mental health conditions, but focuses on visits for substance abuse. From October 2011-September 2012, these visits increased and were above the LHIN target of 18.5%. Alcohol accounts for more than 80% of repeat visits for substance abuse. The Central West LHIN is working with Health Services Providers to

improve access and client experience, particularly in the use of crisis services, to decrease re-visit rates to the emergency departments.

15. 90th percentile wait time for CCAC in-home services – Application from community setting to first CCAC services (excluding case management) – From January-December 2012, 9 out of 10 Central West LHIN residents who live at home and applied for CCAC services received them within at most 30 days. This is three days less than how long Ontarians in general waited, but represents an increase over 2011/12, and was 11 days longer than the LHIN target. The increase in wait time is attributed to several influences: post implementation of new processes, increasing volumes of referrals, decreased capacity on the Access team and the removal of patients from the waitlist.

Engaging Central West LHIN Communities

Aboriginal

Central West LHIN continues to participate in the Provincial Aboriginal Leads Network to ensure that LHINs are working in collaboration to leverage local health initiatives for Aboriginal communities across the province.

Annually the LHIN participates in Cultural Competency Training and the last session was held in May 2012 at the Enaahtig Healing Lodge in the North Simcoe Muskoka LHIN. The focus of this meeting was to gain awareness about aboriginal issues as they relate to the delivery of health services. In addition the focus of planning discussions was to leverage resources across LHINs, particularly as it relates to health services planning in the urban context.

Community Engagement

The Central West LHIN conducted a series of community engagement events in the spring and fall of 2012 to gather feedback from local residents about health care services.

Sixteen sessions were held in Brampton in English and French, Bolton, Malton, Orangeville, Rexdale and Shelburne. Community members were provided with information about the Central West LHIN's role and worked in groups to develop ideas for improving local health care services in their areas.

Sessions were also held with seniors groups from the Rexdale Community Health Centre and India Rainbow's Adult Day program. The LHIN engaged participants at the Punjabi Community Health Centre's annual conference, spoke to congregation members at the Gurdwara Sikh Sangad in Brampton and engaged members at the Enlighten Conference hosted by the Consumer Survivor Network - Central West, for persons with mental health and addictions issues.

Feedback from these events was used to develop the strategic priorities in the Central West LHIN IHSP 3.

French Language Services

The Central West LHIN works closely with Reflet Salvéo, the entity for French language services, to improve access to, and integration of, French language health care services in the communities within the Central West LHIN.

The Central West LHIN also works closely with Health Service Providers that are part of the French Language Services Core Action Group. This group continues to develop strategies for engaging other organizations and communities to build French language services capacity within the local health care system.

As part of the development of Central West LHIN's IHSP 3, the LHIN conducted active engagement of the Francophone community through two Community Engagement Sessions held in French in order to integrate the views and comments of the Francophone community.

The Central West LHIN continues to connect with multi-sector providers of French language services through membership on the Table de concertation francophone de Peel, Dufferin et Halton and the Comité francophone Famille de Peel, in order to develop partnerships to improve French language services within the Central West LHIN.

Women and Children's Focus Groups

In early 2012, the Central West LHIN partnered with Health Service Providers to develop a series of focus groups to gather input from women and young adults in the community.

Groups included South Asian women, teens and seniors from diverse communities, pregnant women and teens, Francophone women, women from Orangeville and mothers from Dufferin County. Each group provided input on current services in the health care system and gave the Central West LHIN suggestions to improve access to health care services for women and children's groups.

Financial statements of

Central West Local Health Integration Network

March 31, 2013

Central West Local Health Integration Network

March 31, 2013

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Deloitte

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Independent Auditor's Report

To the Members of the Board of Directors of the
Central West Local Health Integration Network

We have audited the accompanying financial statements of Central West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2013, and the statements of financial activities, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Central West Local Health Integration network as at March 31, 2013 and the results of its financial activities, change in its net debt and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 22, 2013

Central West Local Health Integration Network

Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	713,180	682,145
Accounts receivable		
Ministry of Health and Long-Term Care ("MOHLTC") - Health Service Providers ("HSP")	4,926,008	969,400
Other	331,371	112,881
	5,970,559	1,764,426
Liabilities		
Accounts payable and accrued liabilities	518,910	382,700
Due to MOHLTC and eHealth Ontario (Note 3b and 3c)	524,722	436,291
Due to HSP	4,926,008	969,400
Due to the LHIN Shared Services Office (Note 4)	13,276	1,056
Deferred capital contributions (Note 5)	108,595	145,133
	6,091,511	1,934,580
Net debt	(120,952)	(170,154)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	12,357	25,021
Capital assets (Note 7)	108,595	145,133
	120,952	170,154
Accumulated surplus	-	-

Approved by the Board

Director

Director

The accompanying notes to the financial statements are an integral part of these financial statements.

Central West Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

	Budget (Note 8)	2013 Actual	2012 Actual
	$	$	$
Revenue			
MOHLTC funding			
Health Service Provider ("HSP") transfer payments (Note 9)	798,351,922	831,241,347	809,798,292
Operations of LHIN	4,181,828	4,126,215	4,362,188
eHealth-Enabling Technologies for Integration (Note 10a)	-	580,000	400,000
French Language Services (Note 10b)	106,000	75,603	106,000
ER/ALC Performance Lead (Note 10c)	100,000	100,000	100,000
Emergency Department Lead (Note 10d)	75,000	75,000	75,000
Aboriginal Health (Note 10e)	7,500	2,500	7,500
Behavioral Support Planning (Note 10f)	-	-	57,000
Primary Care Lead (Note 10g)	75,000	75,000	18,750
Critical Care Lead (Note 10h)	75,000	75,000	75,000
Diabetes Regional Coordination (Note 10i)	-	192,817	-
Amortization of deferred capital contributions (Note 5)	-	62,288	50,184
	802,972,250	836,605,770	815,049,914
Funding repayable to the MOHLTC (Note 3a)	-	(524,722)	(436,291)
	802,972,250	836,081,048	814,613,623
Expenses			
Transfer payments to HSPs (Note 9)	798,351,922	831,241,347	809,798,292
General and administrative (Note 11)	4,181,828	4,155,314	4,208,913
eHealth-Enabling Technologies for Integration (Note 10a)	-	244,823	252,925
French Language Services (Note 10b)	106,000	65,000	89,632
ER/ALC Performance Lead (Note 10c)	100,000	100,000	89,192
Emergency Department Lead (Note 10d)	75,000	72,327	72,768
Aboriginal Health (Note 10e)	7,500	-	-
Behavioral Support Planning (Note 10f)	-	-	17,881
Primary Care Lead (Note 10g)	75,000	72,558	12,000
Critical Care Lead (Note 10h)	75,000	72,000	72,000
Diabetes Regional Coordination (Note 10i)	-	57,679	-
	802,972,250	836,081,048	814,613,623
Annual surplus	-	-	-
Accumulated surplus, beginning of year	-	-	-
Accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

Central West Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2013

	2013	2012
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(25,750)**	(6,780)
Amortization of capital assets	**62,288**	50,184
Change in other non-financial assets	**12,664**	13,628
Decrease in net debt	**49,202**	57,032
Net debt, beginning of year	**(170,154)**	(227,186)
Net debt, end of year	**(120,952)**	(170,154)

The accompanying notes to the financial statements are an integral part of these financial statements.

Central West Local Health Integration Network

Statement of cash flows
year ended March 31, 2013

	2013	2012
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**(62,288)**	(50,184)
Amortization of deferred capital contributions (Note 5)	**62,288**	50,184
Changes in non-cash operating items		
Increase in accounts receivable - MOHLTC	**(3,956,608)**	(111,865)
Increase (decrease) in due to the MOHLTC and eHealth Ontario	**88,431**	(205,000)
Increase in due to HSP's	**3,956,608**	111,865
Increase in accounts receivable - other	**(218,490)**	(17,623)
Decrease in prepaid expenses	**12,664**	13,628
Increase (decrease) in accounts payable	**136,210**	(79,231)
Increase (decrease) in due to the LHIN Shared Services Office	**12,220**	(7,413)
	31,035	(295,639)
Capital transaction		
Acquisition of capital assets	**25,750**	(6,780)
Financing transaction		
(Decrease) increase in deferred capital contributions (Note 5)	**(25,750)**	6,780
Net increase (decrease) in cash	**31,035**	(295,639)
Cash, beginning of year	**682,145**	977,784
Cash, end of year	**713,180**	682,145

The accompanying notes to the financial statements are an integral part of these financial statements.

1. Description of business

The Central West Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Central West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers Dufferin County, the northern portion of Peel Region, part of York Region, and a small part of the City of Toronto. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Services Providers ("HSP"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2013.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets, and losses in the value of assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Funding payments to HSPs in the LHIN geographic area flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2013.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of financial activities, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

2. Significant accounting policies (continued)

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of financial activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Adoption of new accounting standards

As at April 1, 2012, the LHIN adopted Public Sector Accounting Handbook *Section PS 1201, "Financial Statement Presentation"*, Section PS 2601 *"Foreign Currency Translation"*, PS 3410 "*Government Transfers*" and Section PS 3450, *"Financial Instruments"*. There was no impact of the adoption of these new standards on the financial statements.

3. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the MLPA and TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC and eHealth Ontario, respectively.

a. The amount repayable to the MOHLTC and eHealth Ontario related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2013 Excess funding	2012 Excess funding
	$	$	$	$
Transfer Payments to HSP's	831,241,347	831,241,347	-	-
LHIN Operations (Note 11)	4,126,215	4,093,026	33,189	203,459
Capital contribution (Note 11)	62,288	62,288	-	-
eHealth - Enabling Technologies for Integration (Note 10a)	580,000	244,823	335,177	147,075
French Language Services (Note 10b)	75,603	65,000	10,603	16,368
ER/ALC Performance Lead (Note 10c)	100,000	100,000	-	10,808
Emergency Department Lead (Note 10d)	75,000	72,327	2,673	2,212
Aboriginal Health (Note 10e)	2,500	-	2,500	7,500
Behavioural Support Planning (Note 10f)	-	-	-	39,119
Primary Care Lead (Note 10g)	75,000	72,558	2,442	6,750
Critical Care Lead (Note 10h)	75,000	72,000	3,000	3,000
Diabetes Regional Co-ordination (Note 10i)	192,817	57,679	135,138	-
	836,605,770	836,081,048	524,722	436,291

b. The amount due to the MOHLTC at March 31 is made up as follows:

	2013	2012
	$	$
Due to MOHLTC, beginning of year	289,216	641,291
Funding repaid to MOHLTC prior year	(289,216)	(641,291)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	524,722	289,216
Due to MOHLTC, end of year	524,722	289,216

3. Funding repayable to the MOHLTC and eHealth Ontario (continued)

c. The amount due to eHealth Ontario at March 31 is made up as follows:

	2013	2012
	$	$
Due to eHealth Ontario, beginning of year	**147,075**	-
Funding repaid to eHealth Ontario related to current year activities (Note 3a)	**(147,075)**	147,075
Due to eHeath Ontario, end of year	-	147,075

In the previous fiscal year (2011-12) the LHIN was funded by MOHLTC through the MLPA and eHealth Ontario directly in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect the one time funding arrangement for comparative purposes. In the current fiscal year (2012-13) the funding for eHealth Initiatives with respect to Enabling Technologies for Integration are incorporated as part of the budget arrangements of the MLPA.

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2013	2012
	$	$
Balance, beginning of year	**145,133**	188,537
Capital contributions received during the year	**25,750**	6,780
Amortization for the year	**(62,288)**	(50,184)
Balance, end of year	**108,595**	145,133

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment ending in 2015. Lease renewals are likely. Minimum lease payments due in each of the next two years are as follows:

	$
2014	220,835
2015	125,899
	346,734

6. Commitments (continued)

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2010. Minimum funding for HSPs related to the next two years, based on the fiscal 2012 accountability agreements, and are as follows:

	$
2014	799,877,100
2015	799,877,100

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2013 Net book value	2012 Net book value
	$	$	$	$
Office furniture and fixtures	**284,229**	**265,394**	**18,835**	29,844
Computer equipment	**60,177**	**43,010**	**17,167**	-
Leasehold improvements	703,569	630,976	72,593	115,289
	1,047,975	**939,380**	**108,595**	145,133

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the statement of financial activities reflect the final budget at April 30, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year, the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $834,295,418 is made up of the following:

	$
Initial HSP funding budget	798,351,922
Adjustment due to announcements made during the year	35,943,496
Total HSP funding budget	834,295,418

The $3,054,071 difference between the final budget of $834,295,418 and the actual expenses of $831,241,347 relates primarily to late in year new funding approvals.

8. Budget figures (continued)

The total operating budget, excluding HSP funding, is made up of the following:

	$
Initial budget	4,181,828
In Year Surplus returned to MOHLTC	(29,866)
Aboriginal Funding	7,500
In Year Surplus returned to MOHLTC	(5,000)
French Language Services	106,000
In Year Surplus returned to MOHLTC	(30,397)
ER/ALC Performance Lead	100,000
ED LHIN Lead	75,000
Primary Care Lead	75,000
Critical Care Lead	75,000
Adjustment due to announcements made during the year	
eHealth - Enabling Technologies for Integration	580,000
Diabetes Regional Co-ordination	192,817
Amount treated as capital contributions made during the year	(25,750)
Total budget	5,302,132

9. Transfer payments to HSPs

The LHIN approved transfer payments to the various sectors in 2013 as follows:

	2013	2012
	$	$
Operation of Hospitals	**531,748,267**	516,703,101
Grants to compensate for Municipal Taxation - Public Hospitals	**99,450**	99,450
Long-Term Care Homes	**148,870,896**	148,451,157
Community Care Access Centres	**93,211,762**	89,894,131
Community Support Services	**9,331,737**	8,280,728
Assisted Living Services in Supportive Housing	**6,585,023**	6,265,236
Community Health Centres	**10,138,849**	9,933,667
Community Mental Health Addictions Program	**31,255,363**	30,170,822
	831,241,347	809,798,292

10. Specific initiatives

Separate funding amounts were received by the Central West LHIN from the MOHLTC and eHealth Ontario for specific initiatives.

a) eHealth – Enabling Technologies for Integration

The LHIN received funding of $580,000 (2012 - $400,000) related to supporting the eHealth PMO office. eHealth expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	225,083	245,954
Staff travel	2,436	2,556
Communication expense	1,831	529
Consulting	-	25
Accomodation	5,895	3,600
Staff development	253	-
Meeting expenses	142	261
Supplies	9,183	-
	244,823	252,925

b) French Language Services

The LHIN received base funding of $106,000 (2012 - $106,000) this was further reduced by a one time in year recovery of $30,397 in the fourth Quarter to reflect a final initiative revenue of $75,603 for French Language Services. Expenses incurred during the year of $65,000 (2012 - $89,632) consist of salary and benefits of $57,528 for the French Language Coordinator and $7,472 in meeting and administration expenses.

c) ER/ALC Performance Lead

The LHIN received funding of $100,000 (2012 - $100,000) related to the ER/ALC Performance Lead initiative. ER/ALC expenses incurred during the year of $100,000 (2012 - $89,192) related to salaries and benefits.

d) Emergency Department Lead

The LHIN received funding of $75,000 (2012 - $75,000) related to the Emergency Department Lead project. Emergency Department Lead expenses of $72,327 (2012 - $72,788) consist of $72,000 (2012 - $72,000) for Medical Professional Services and $327 (2012 - $788) related to development and travel expenses.

e) Aboriginal Health

The LHIN received base funding of $7,500 (2012 - $7,500) related to the Aboriginal Health planning. This funding was further reduced by ($5,000) one-time in year recovery in the fourth quarter for a final revised funding available for Aboriginal Health Planning of $2,500. Aboriginal Health planning expenses incurred during the year consist of $Nil (2012 - $Nil). Development of the community engagement strategy will resume in 2013-14.

f) Behavioral Support Planning

The planning initiative for Behavioral Support Operations was incorporated into base LHIN funding for the current year and the LHIN received $Nil (2012 – revenue $57,000 and expenses of $17,881).

10. Specific initiatives (continued)

g) Primary Care Lead

The LHIN received funding of $75,000 (2012 - $18,750) related to the Primary Care Lead project. Primary Care Lead expenses of $72,558 (2012 - $12,000) consist of $72,000 (2012 - $12,000) for Medical Professional Services and $558 (2012 - $Nil) related to travel expenses.

h) Critical Care Lead

The LHIN received funding of $75,000 (2012 - $75,000) related to the Critical Care Lead project. Critical Care Lead expenses incurred during the year consist of $72,000 (2012 - $72,000) for Medical Professional Services.

i) Diabetes Regional Co-ordination

The LHIN received funding of $192,817 (2012 - $Nil) related to supporting the Diabetes Regional Co-ordination. Diabetes Regional Co-ordination expenses incurred during the year is as follows:

	2013	2012
	$	$
Salaries and benefits	21,765	-
Staff travel	246	-
Communication expense	21,503	-
Accomodation	5,350	-
Staff development	150	-
Meeting expenses	1,690	-
Supplies	6,975	-
	57,679	-

11. General and administrative expenses

The statement of financial activities presents expenses by function. The following classifies these same expenses by object:

	2013	2012
	$	$
Salaries and benefits	2,692,303	2,643,710
Occupancy	240,118	255,406
Amortization	62,288	50,184
Shared services	411,520	475,025
LHIN Collaborative	47,500	26,971
Consulting services	148,237	226,067
Professional Fees	25,115	23,005
Supplies	77,617	74,857
Board Chair remuneration	69,125	60,900
Board member remuneration	76,050	78,650
Board expenses	44,980	30,690
Mail, courier and telecommunications	61,697	41,386
Other	198,764	222,062
	4,155,314	4,208,913

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 25 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was $266,578 (2012 - $228,377) for current service costs and is included as an expense in the statement of financial activities. The last actuarial valuation was completed for the plan as at December 31, 2012. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the *Financial Administration Act*.